Kansas Medical Assistance Program Prior Authorization Request Form for Non-Preferred Drugs

AX completed form to the Prior Authorization Unit 1-800-913-2229 (274-5956 Topeka) Physician signature Date Unless otherwise indicated, the chemical name includes branded products and all dosage forms. ANTIEMETIC DRUGS - Serotonin 5HT3 Antagonists referred Drug Covered Indansetron Indansetron Indicates REQUIRED information *CONSUMER NAME: **Medicaid Number: **Phone #: **Fax #: **Medicaid #: **NPI #: **NDC: **Indicate: Non-Preferred Drug prescribed: **Indicate: Non-Preferred Drug tried: **Phone #: **Fax #: **Medicaid #: **Phone #: **Fax #: **Medicaid #: **Phone #: **Fax #: **Indicate: Preferred Drug tried: **Check: the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information: Medical intolerance to Preferred Drug. Provide clinical symptoms: Inadequate response to Preferred Drug. Inadequate response to Preferred Drug.	If you would like to prescribe a Preferred Dr Please do so in the space provided and FAX form back to the dispensing pharmacy	ng, Rx
### Medicaid ### ### Medicaid ### ### Medicaid ### ### Indicate: Preferred Drug tried: ### Medicaid ### ### ### Medicaid ### ### Medicaid ### ### Medicaid ### ### ### Medicaid ### ### ### ### Medicaid ### ### ### ### ### ### ### ### ### #	process by completing the rest of this form &	Unit
ANTIEMETIC DRUGS - Serotonin 5HT3 Antagonists referred Drug Covered Indansetron Zofran® Zofran ODT®		Physician signature Date
ANTIEMETIC DRUGS - Serotonin 5HT3 Antagonists referred Drug Covered Indansetron Zofran® Zofran ODT®	Unless otherwise indicated the che	nical name includes branded products and all dosage forms
Non-preferred Prior Authorization Require	-	
Dolasetron Zofran® Zofran ODT®		
* Indicates REQUIRED information *CONSUMER NAME:	Ondansetron Zofran®	
* Indicates REQUIRED information *CONSUMER NAME:		, , ,
* Indicates REQUIRED information *CONSUMER NAME:		
**Medicaid Number: **PHARMACY Name: **Phone #: **NPI #: **NDC: **Indicate: Non-Preferred Drug prescribed: **PRESCRIBER Name: **Phone #: **Fax #: **PRESCRIBER Name: **Phone #: **Fax #: **Indicate: Preferred Drug tried: **Indicate: Preferred Drug tried: **Indicate: Preferred Drug tried: **Check: the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information: Medical intolerance to Preferred Drug. Provide clinical symptoms: Inadequate response to Preferred Drug.	_	Granisetron, Topical Sancuso®
** Indicate: Non-Preferred Drug prescribed:	**CONSUMER NAME:	
** Indicate: Non-Preferred Drug prescribed:	** Medicaid #:	**NPI #:
**Medicaid #: NPI #: ** Indicate: Preferred Drug tried: Length of trial: * Check: the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information: Medical intolerance to Preferred Drug. Provide clinical symptoms: Inadequate response to Preferred Drug.		
** Indicate: Preferred Drug tried: Length of trial: * Check: the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information: Medical intolerance to Preferred Drug. Provide clinical symptoms: Inadequate response to Preferred Drug.	**PRESCRIBER Name:	**Phone #:**Fax #:
* Check: the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information: Medical intolerance to Preferred Drug. Provide clinical symptoms: Inadequate response to Preferred Drug.	**Medicaid #:	NPI #:
and provide the requested information: Medical intolerance to Preferred Drug. Provide clinical symptoms: Inadequate response to Preferred Drug.	** Indicate: Preferred Drug tried:	Length of trial:
Inadequate response to Preferred Drug.		ical necessity for the Non-Preferred Drug
	Medical intolerance to Preferred Drug.	Provide clinical symptoms:
Absongs of appropriate formulation as indication of the days Discourse if	Inadequate response to Preferred Drug	
Absence of appropriate formulation or indication of the drug. Please specify:	Absence of appropriate formulation or	ndication of the drug. Please specify:
Absongs of appropriate formulation on indication of the day Diversity	** Check: the appropriate box indicating med and provide the requested information: Medical intolerance to Preferred Drug.	ical necessity for the Non-Preferred Drug

If the pharmacy provider has started a Prior Authorization request and this information is not received within 15 working days, the PA request will be denied. **For questions related to Prior Authorization, contact 800-285-4978, option #3 or 274-5499, in Topeka.** General support is provided at 800-933-6593.

Revised 2009-08-27